FOR OHF USE

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044289

Facility Name: SOMERSET PLACE

Address: 5009 SHERIDAN ROAD (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 561-0700 **Fax #** (773) 561-9843

IDPA ID Number: 364269377001

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) See Accountants' Compilation Report Attached (Date)
(Print Name and Title) EDWARD N. SLACK, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	450	Intermediate (ICF)	450	164,250	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	450	TOTALS	450	164,250	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	150,873	461		151,334	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	150,873	461		151,334	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.14%

D. How many bed-hold days during this year were paid by Public Aid?
5,527 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	408,626	73,320	40,878	522,824		522,824	(13,695)	509,129			1
2	Food Purchase		443,948		443,948		443,948	(1,691)	442,257			2
3	Housekeeping	319,534	69,102		388,636		388,636	(1,374)	387,262			3
4	Laundry	17,156	5,357	76,919	99,432		99,432		99,432			4
5	Heat and Other Utilities			248,582	248,582		248,582	3,917	252,499			5
6	Maintenance	145,864		287,961	433,825		433,825	9,525	443,350			6
7	Other (specify):*							8,874	8,874			7
8	**TOTAL General Services**	891,180	591,727	654,340	2,137,247		2,137,247	5,556	2,142,803			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	2,529,286	69,163	6,160	2,604,609		2,604,609	21,484	2,626,093			10
10a	Therapy	20,429		2,264	22,693		22,693		22,693			10a
11	Activities	297,949	18,748	8,566	325,263		325,263	51	325,314			11
12	Social Services	692,796	7,785	8,904	709,485		709,485	33	709,518			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							6,282	6,282			15
16	**TOTAL Health Care and Programs**	3,540,460	95,696	37,894	3,674,050		3,674,050	27,850	3,701,900			16
	C. General Administration											
17	Administrative	424,068		343,090	767,158		767,158	(220,576)	546,582			17
18	Directors Fees											18
19	Professional Services			637,279	637,279		637,279	(574,259)	63,020			19
20	Dues, Fees, Subscriptions & Promotions			92,453	92,453		92,453	(52,778)	39,675			20
21	Clerical & General Office Expenses	191,077	32,905	231,275	455,257		455,257	108,926	564,183			21
22	Employee Benefits & Payroll Taxes			866,847	866,847		866,847	(19,270)	847,577			22
23	Inservice Training & Education			2,848	2,848		2,848		2,848			23
24	Travel and Seminar			1,585	1,585		1,585	2,255	3,840			24
25	Other Admin. Staff Transportation			16,204	16,204		16,204	(10,140)	6,064			25
26	Insurance-Prop.Liab.Malpractice			161,387	161,387		161,387	2,755	164,142			26
27	Other (specify):*							51,347	51,347			27
28	**TOTAL General Administration**	615,145	32,905	2,352,968	3,001,018		3,001,018	(711,740)	2,289,278			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,046,785	720,328	3,045,202	8,812,315		8,812,315	(678,333)	8,133,982			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SOMERSET PLACE #0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			88,531	88,531		88,531	550,405	638,936			30
31	Amortization of Pre-Op. & Org.			6,590	6,590		6,590		6,590			31
32	Interest							2,244,666	2,244,666			32
33	Real Estate Taxes			574,368	574,368		574,368	6,798	581,166			33
34	Rent-Facility & Grounds			2,742,975	2,742,975		2,742,975	(2,732,473)	10,502			34
35	Rent-Equipment & Vehicles			12,150	12,150		12,150	7,629	19,779			35
36	Other (specify):*							1,064,404	1,064,404			36
37	TOTAL Ownership			3,424,614	3,424,614		3,424,614	1,141,429	4,566,043			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,732	203	1,935		1,935		1,935			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			246,375	246,375		246,375		246,375			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,732	246,578	248,310		248,310		248,310			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,046,785	722,060	6,716,394	12,485,239		12,485,239	463,095	12,948,334			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(73,352)	30		9
10	Interest and Other Investment Income	(209,743)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(13)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(144,000)	21		24
25	Fund Raising, Advertising and Promotional	(7,918)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(90)			28
29	Other-Attach Schedule	(321,215)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (756,581)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,219,587		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,219,587		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 463,005		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

SOMERSET PLACE

ID# 0044289

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL ON LTC-COPE	$ (6,578)	20	1
2	BANK CHARGES	(8,364)	21	2
3	THEFT LOSS	(222)	21	3
4	SALES TAX - PRIOR PERIOD ADJUSTMENT	(1,341)	02	4
5	PRIOR PERIOD LEGAL FEES	(1,018)	19	5
6	JURY DUTY	(203)	10	6
7	MISCELLANEOUS INCOME	(128)	21	7
8	COLLECTION EXPENSE	(190)	21	8
9	LLC FEES (BUILDING CO)	(300)	20	9
10	TRUST FEES (BUILDING CO)	(200)	20	10
11	CAPITALIZED R & M	(2,671)	06	11
12	E. ROTHNER ADMINISTRATIVE SALARY	(300,000)	17	12
13				13
14				14
15				15
16				16
17				17
18				18
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91				91
92				92
93				93
94				94
95				95
96				96
97				97
98				98
99				99
100				100
101	Total	(321,215)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(4,488)		(9,207)					(13,695)	1
2	Food Purchase	(1,354)		(337)									(1,691)	2
3	Housekeeping				161			(1,535)					(1,374)	3
4	Laundry													4
5	Heat and Other Utilities			3,917									3,917	5
6	Maintenance	(2,671)		7,663		4,533							9,525	6
7	Other (specify):*				6,648	2,226							8,874	7
8	**TOTAL General Services**	(4,025)		11,243	6,809	2,271		(10,741)					5,556	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(203)		(93)		28,088		(6,308)					21,484	10
10a	Therapy													10a
11	Activities			5	46								51	11
12	Social Services					33							33	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				2,413	3,869							6,282	15
16	**TOTAL Health Care and Programs**	(203)		(88)	2,459	31,990		(6,308)					27,850	16
	C. General Administration													
17	Administrative	(300,000)		922	35	78,467							(220,576)	17
18	Directors Fees													18
19	Professional Services	(1,018)		(573,241)									(574,259)	19
20	Fees, Subscriptions & Promotions	(15,246)	500	(38,032)									(52,778)	20
21	Clerical & General Office Expenses	(152,904)		37,788		224,042							108,926	21
22	Employee Benefits & Payroll Taxes				(19,270)								(19,270)	22
23	Inservice Training & Education													23
24	Travel and Seminar			2,255									2,255	24
25	Other Admin. Staff Transportation			(10,140)									(10,140)	25
26	Insurance-Prop.Liab.Malpractice			2,755									2,755	26
27	Other (specify):*				8,728	42,619							51,347	27
28	**TOTAL General Administration**	(469,168)	500	(577,693)	(10,507)	345,128							(711,740)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(473,396)	500	(566,538)	(1,239)	379,389		(17,049)					(678,333)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SOMERSET PLACE # 0044289 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(73,352)	596,753	27,004									550,405	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(209,743)	2,425,608	28,801									2,244,666	32
33	Real Estate Taxes			6,798									6,798	33
34	Rent-Facility & Grounds		(2,742,975)	10,502									(2,732,473)	34
35	Rent-Equipment & Vehicles			7,629									7,629	35
36	Other (specify):*		1,064,404										1,064,404	36
37	**TOTAL Ownership**	(283,095)	1,343,790	80,734									1,141,429	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(756,491)	1,344,290	(485,804)	(1,239)	379,389		(17,049)					463,095	45

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				SOMERSET REAL ESTATE, LLC		BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 2,742,975	SOMERSET REAL ESTATE, LLC		$	$ (2,742,975)	1
2	V	32	INTEREST INCOME	13,072	SOMERSET REAL ESTATE, LLC			(13,072)	2
3	V	20	TRUST FEES		SOMERSET REAL ESTATE, LLC		200	200	3
4	V	30	DEPRECIATION		SOMERSET REAL ESTATE, LLC		596,753	596,753	4
5	V	32	MORTGAGE INTEREST		SOMERSET REAL ESTATE, LLC		2,438,680	2,438,680	5
6	V	20	LLC FEES		SOMERSET REAL ESTATE, LLC		300	300	6
7	V	36	MORTGAGE INSURANCE		SOMERSET REAL ESTATE, LLC		142,605	142,605	7
8	V	36	AMORTIZATION		SOMERSET REAL ESTATE, LLC		921,799	921,799	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 2,756,047			$ 4,100,337	$ * 1,344,290	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	05	Utilities	$	Care Centers, Inc.	100.00%	$ 3,917	$ 3,917	15
16	V	06	Maintenance		Care Centers, Inc.	100.00%	7,663	7,663	16
17	V	10	Nursing	112	Care Centers, Inc.	100.00%	19	(93)	17
18	V	11	Activities		Care Centers, Inc.	100.00%	5	5	18
19	V	19	Professional Fees	596,063	Care Centers, Inc.	100.00%	22,822	(573,241)	19
20	V	20	Dues and Subscriptions	41,063	Care Centers, Inc.	100.00%	3,031	(38,032)	20
21	V	21	Office & Clerical		Care Centers, Inc.	100.00%	37,788	37,788	21
22	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	2,255	2,255	22
23	V	26	Insurance		Care Centers, Inc.	100.00%	2,755	2,755	23
24	V	30	Depreciation		Care Centers, Inc.	100.00%	27,004	27,004	24
25	V	32	Interest		Care Centers, Inc.	100.00%	28,801	28,801	25
26	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	6,798	6,798	26
27	V	34	Rent - Building		Care Centers, Inc.	100.00%	10,502	10,502	27
28	V	35	Rent - Equipment & Auto		Care Centers, Inc.	100.00%	7,629	7,629	28
29	V	25	Bus Reimbursement	10,140	Care Centers, Inc.	100.00%		(10,140)	29
30	V	02	Food	337	Care Centers, Inc.	100.00%		(337)	30
31	V	17	Administration		Care Centers, Inc.	100.00%	922	922	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 647,715			$ 161,911	$ * (485,804)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	03	Housekeeping Salary	$ 45,506	Care Centers, Inc.	100.00%	$ 45,667	$ 161	15
16	V	06	Maintenance Salary	904	Care Centers, Inc.	100.00%	904		16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	6,648	6,648	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%			18
19	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			19
20	V	11	Activity Salary	8,374	Care Centers, Inc.	100.00%	8,420	46	20
21	V	12	Social Service Salary	8,845	Care Centers, Inc.	100.00%	8,845		21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	2,413	2,413	22
23	V	17	Administration Salary	31,090	Care Centers, Inc.	100.00%	31,125	35	23
24	V	21	Office Salary	33,746	Care Centers, Inc.	100.00%	33,746		24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	8,728	8,728	25
26	V	22	Employee Benefits	19,270	Care Centers, Inc.	100.00%		(19,270)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 147,735			$ 146,496	$ * (1,239)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$ 16,425	Care Centers, Inc.	100.00%	$ 11,937	$ (4,488)	15
16	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,533	4,533	16
17	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	2,226	2,226	17
18	V	10	Nursing Salary		Care Centers, Inc.	100.00%	28,088	28,088	18
19	V	12	Social Service Salary		Care Centers, Inc.	100.00%	33	33	19
20	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,869	3,869	20
21	V	17	Administration Salary		Care Centers, Inc.	100.00%	78,467	78,467	21
22	V	21	Office Salary		Care Centers, Inc.	100.00%	224,042	224,042	22
23	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	42,619	42,619	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 16,425			$ 395,814	$ * 379,389	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc. - Health Systems Division	100.00%	$	$	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%			16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%			17
18	V	10	Nursing		Care Centers, Inc. - Health Systems Division	100.00%			18
19	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%			19
20	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%			20
21	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%			21
22	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%			22
23	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%			23
24	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%			24
25	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%			25
26	V	39	Ancillary Enteral Supplies		Care Centers, Inc. - Health Systems Division	100.00%			26
27	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%			27
28	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%			28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 67,954	XCEL Medical Supply, LLC	100.00%	$ 58,747	$ (9,207)	15
16	V	03	Housekeeping	11,326	XCEL Medical Supply, LLC	100.00%	9,791	(1,535)	16
17	V	10	Nursing	46,561	XCEL Medical Supply, LLC	100.00%	40,253	(6,308)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 125,840			$ 108,791	$ * (17,049)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 265,336	$ 265,336	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	265,336				(265,336)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 265,336			$ 265,336	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0	See Attached	4.52	6.28%	Salary	$ 300,000	17-01	1
2	Melissa Rothner	Owner	Clerical	6.67%	See Attached			Salary	93	21-07	2
3	Mark Steinberg	Relative	Administrative	0	See Attached	4.61	9.22%	Salary	4,175	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 304,268		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	05	Utilities	Patient Days	1,640,756	39	$ 42,470	$	151,334	$ 3,917	1
2	06	Maintenance	Patient Days	1,640,756	39	83,080		151,334	7,663	2
3	10	Nursing	Patient Days	1,640,756	39	205		151,334	19	3
4	11	Activities	Patient Days	1,640,756	39	51		151,334	5	4
5	19	Professional Fees	Patient Days	1,640,756	39	247,437		151,334	22,822	5
6	20	Dues and Subscriptions	Patient Days	1,640,756	39	32,863		151,334	3,031	6
7	21	Office & Clerical	Patient Days	1,640,756	39	409,698		151,334	37,788	7
8	24	Travel and Seminar	Patient Days	1,640,756	39	53,743		151,334	2,255	8
9	26	Insurance	Patient Days	1,640,756	39	29,875		151,334	2,755	9
10	30	Depreciation	Patient Days	1,640,756	39	292,776		151,334	27,004	10
11	32	Interest	Patient Days	1,640,756	39	312,254		151,334	28,801	11
12	33	Real Estate Taxes	Patient Days	1,640,756	39	73,702		151,334	6,798	12
13	34	Rent - Building	Patient Days	1,640,756	39	113,857		151,334	10,502	13
14	35	Rent - Equipment & Auto	Patient Days	1,640,756	39	82,710		151,334	7,629	14
15	17	Administration	Patient Days	1,640,756	39	10,000		151,334	922	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,784,721	$		$ 161,911	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	03	Housekeeping Salary	Direct Cost			45,667	45,667		45,667	1
2	06	Maintenance Salary	Direct Cost			169,934	169,934		904	2
3	07	Emp. Ben. - Gen. Serv.	Direct Cost			29,646			6,648	3
4	10	Nursing Salary	Direct Cost			895,582	895,582			4
5	10a	Rehab Salary	Direct Cost			128,376	128,376			5
6	11	Activity Salary	Direct Cost			57,201	57,201		8,420	6
7	12	Social Service Salary	Direct Cost			219,790	219,790		8,845	7
8	15	Emp. Ben. - Healthcare	Direct Cost			180,204			2,413	8
9	17	Administration Salary	Direct Cost			1,334,207	1,334,207		31,125	9
10	21	Office Salary	Direct Cost			584,278	584,278		33,746	10
11	27	Emp. Ben. - Gen. Admin.	Direct Cost			267,060			8,728	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,911,943	$ 3,435,033		$ 146,496	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,640,756	39	129,417	129,417	151,334	11,937	1
2	06	Maintenance Salary	Patient Days	1,640,756	39	49,148	49,148	151,334	4,533	2
3	07	Emp. Ben. - Gen. Serv.	Patient Days	1,640,756	39	24,132		151,334	2,226	3
4	10	Nursing Salary	Patient Days	1,640,756	39	304,530	304,530	151,334	28,088	4
5	12	Social Service Salary	Patient Days	1,640,756	39	354	354	151,334	33	5
6	15	Emp. Ben. - Healthcare	Patient Days	1,640,756	39	41,952		151,334	3,869	6
7	17	Administration Salary	Patient Days	1,640,756	39	850,731	850,731	151,334	78,467	7
8	21	Office Salary	Patient Days	1,640,756	39	2,429,052	2,429,052	151,334	224,042	8
9	27	Emp. Ben. - Gen. Admin.	Patient Days	1,640,756	39	462,069		151,334	42,619	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 4,291,386	$ 3,763,233		$ 395,814	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2202 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,191,458		182,448				1
2	02	Food	Billable Income	2,191,458		834,365				2
3	06	Maintenance	Billable Income	2,191,458		1,400				3
4	10	Nursing	Billable Income	2,191,458		850				4
5	17	Administration	Billable Income	2,191,458		23,000				5
6	19	Professional Fees	Billable Income	2,191,458		46,205				6
7	20	Dues & Subscriptions	Billable Income	2,191,458		2,514				7
8	21	Office & Clerical	Billable Income	2,191,458		33,124				8
9	24	Travel & Seminar	Billable Income	2,191,458		49,456				9
10	34	Rent - Building	Billable Income	2,191,458		1,300				10
11	35	Rent - Equipment & Auto	Billable Income	2,191,458		1,830				11
12	39	Ancillary Enteral Supplies	Billable Income	2,191,458		84,436				12
13	01	Dietary - Salary	Billable Income	2,191,458		436,887	436,887			13
14	07	Emp. Ben. - Gen. Serv.	Billable Income	2,191,458		58,714				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,756,530	$ 436,887		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Xcel Medical Supply, LLC
Street Address: 2201 Main Street
City / State / Zip Code: Evanston, IL 60202
Phone Number: (847) 328-7600
Fax Number: (847) 328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Direct Allocation			$	$		$ 58,747	1
2	03	Housekeeping	Direct Allocation						9,791	2
3	10	Nursing	Direct Allocation						40,253	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 108,791	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 W. MAIN ST.
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847) 905-4000
Fax Number: (847) 905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 265,336	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 265,336	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	BUILDING PARTNERSHIP	X		MORTGAGE		01/28/99	$	$ 28,450,741		PRIME+1	$ 2,438,680	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$ 28,450,741			$ 2,438,680	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(194,014)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (194,014)	14
15	TOTALS (line 9+line14)						$	$ 28,450,741			$ 2,244,666	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 142,605 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income			Money Market			$	$			$ (209,743)	1
2	Interest Income (Bldg Co.)										(13,072)	2
3	Allocation from Care Centers, Inc.										28,801	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (194,014)	21

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	587,799	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	581,166	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,633)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	587,799	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	581,166	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998	572,691	9
1999	568,847	10
2000	559,809	11
2001	574,368	12

2002 Accrual = $587,799-$574,368*1.023=587,799

CCI Allocation - $6,798 is in Line 2

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOMERSET PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-08-408-003-0000	Long Term Care Property	$ 567,241.08	$ 567,241.08
2.	14-08-408-031-0000	Long Term Care Property	$ 7,127.25	$ 7,127.25
3.	15-17-304-081, 03-0120-567	Home Office Allocation	$ 70,261.69	$ 6,480.54
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 644,630.02	$ 580,848.87

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SOMERSET PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044289

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 184,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 9

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 287,686
2. Number of Years Over Which it is Being Amortized: _____
3. Current Period Amortization: 6,590
4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 1,100,000	1
2	Care Center Allocation			38,794	2
3	TOTALS			$ 1,138,794	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		10,603,664	316,011		317,299	1,288	1,036,924	68
69	Financial Statement Depreciation			47,133			(47,133)		69
70	TOTAL (lines 4 thru 69)		$ 10,603,664	$ 363,144		$ 317,299	$ (45,845)	$ 1,036,924	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,603,664	$ 363,144		$ 317,299	$ (45,845)	$ 1,036,924	1
2	BLDG RENOVATION	1999	7,400		20	370	370	1,449	2
3	HEATER RENOVATION	1999	520		20	26	26	102	3
4	PIPING RENOVATION	1999	3,829		20	191	191	733	4
5	PLUMBING RENOVATION	1999	638		20	32	32	123	5
6	DOOR	1999	750		20	38	38	142	6
7	ELEVATOR RENOVATION	1999	597		20	30	30	113	7
8	PLUMBING RENOVATION	1999	1,296		20	65	65	244	8
9	PLUMBING RENOVATION	1999	1,980		20	99	99	363	9
10	ELECTRIC RENOVATION	1999	959		20	48	48	176	10
11	ELECTRIC RENOVATION	1999	225		20	11	11	40	11
12	BOILER RENOVATION	1999	643		20	32	32	117	12
13	BOILER RENOVATION	1999	2,075		20	104	104	381	13
14	BOILER RENOVATION	1999	869		20	43	43	158	14
15	A/C RENOVATION	1999	1,950		20	98	98	351	15
16	ELECTRIC RENOVATION	1999	964		20	48	48	168	16
17	A/C RENOVATION	1999	2,478		20	124	124	434	17
18	WATER HEATER	1999	5,870		20	294	294	1,005	18
19	WATER HEATER	1999	933		20	47	47	161	19
20	LOCKS	1999	744		20	37	37	120	20
21	HOT WATER PUMP	1999	933		20	47	47	161	21
22	A/C IMPROVEMENT	1999	996		20	50	50	167	22
23	BOILER	1999	839		20	42	42	137	23
24	LOOSE SILL REMOVAL	2000	74,460		20	3,723	3,723	11,169	24
25	SINKS	2000	3,398		20	170	170	496	25
26	EXIT CONTROL LOCK	2000	1,647		20	82	82	239	26
27	GENERATOR	2000	1,414		20	71	71	207	27
28	PHONE SYSTEM INSTALL	2000	26,841		20	1,342	1,342	3,914	28
29	HOT WATER HEATER REP	2000	9,500		20	475	475	1,346	29
30	PAINT	2000	1,939		20	97	97	275	30
31	BLINDS	2000	6,223		20	311	311	881	31
32	CARPET INSTALLATION	2000	750		20	38	38	105	32
33	GAS PUMP REPAIR	2000	1,235		20	62	62	171	33
34	TOTAL (lines 1 thru 33)		$ 10,768,559	$ 363,144		$ 325,546	$ (37,598)	$ 1,062,572	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 10,768,559	$ 363,144		$ 325,546	$ (37,598)	$ 1,062,572	1
2	ELECTRIC WIRING	2000	1,143		20	57	57	157	2
3	PAINT	2000	3,809		20	190	190	507	3
4	WINDOW TREATMENTS	2000	6,562		20	328	328	875	4
5	TILES	2000	2,377		20	119	119	317	5
6	RENOVATION OF 117 BA	2000	22,815		20	1,141	1,141	3,043	6
7	ROOF LEAK REPAIR	2000	1,247		20	62	62	165	7
8	NEW BOILER	2000	784		20	39	39	104	8
9	PLUMBING WORK	2000	5,550		20	278	278	741	9
10	EXHAUST SYSTEM REPAI	2000	66,798		20	3,340	3,340	8,907	10
11	BOILER REPAIR	2000	601		20	30	30	80	11
12	NEW CARPETING	2000	3,400		20	170	170	453	12
13	PAINT	2000	559		20	28	28	72	13
14	PAINT	2000	217		20	11	11	28	14
15	PAINT	2000	564		20	28	28	72	15
16	FACADE PROJECT	2000	9,451		20	473	473	1,222	16
17	12 KNOB SETS	2000	919		20	46	46	119	17
18	SNEEZE GUARD	2000	7,631		20	382	382	987	18
19	FIRE ALARM SYSTEM RE	2000	1,100		20	55	55	142	19
20	EXHAUST MOTOR REPAIR	2000	3,730		20	187	187	483	20
21	PLUMBING REPAIR	2000	9,974		20	499	499	1,289	21
22	DRYWALL	2000	502		20	25	25	65	22
23	LANDSCAPING	2000	46,025		20	2,301	2,301	5,944	23
24	AWNING FRAMES & FIXT	2000	10,000		20	500	500	1,292	24
25	TILES INSTALLATION	2000	10,558		20	528	528	1,364	25
26	NEW CARPETING	2000	10,000		20	500	500	1,292	26
27	SEWER REPAIR	2000	653		20	33	33	85	27
28	LIGHT FIXTURES	2000	1,642		20	82	82	212	28
29	REPLACE THERMOSTAT	2000	1,719		20	86	86	222	29
30	PAINT	2000	1,873		20	94	94	235	30
31	AVIARY	2000	7,966		20	398	398	995	31
32	NEW BOILER DRAIN	2000	598		20	30	30	75	32
33	LIGHT FIXTURES,LAMPS	2000	76,263		20	3,813	3,813	9,533	33
34	TOTAL (lines 1 thru 33)		$ 11,085,589	$ 363,144		$ 341,399	$ (21,745)	$ 1,103,649	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 11,085,589	$ 363,144		$ 341,399	$ (21,745)	$ 1,103,649	1
2	DRYWALL	2000	717		20	36	36	90	2
3	ELECTRICAL SUPPLIES	2000	622		20	31	31	78	3
4	LIFE SAFETY CODE REV	2000	1,239		20	62	62	155	4
5	FIRE DOORS	2000	1,864		20	93	93	233	5
6	NEW FRAME	2000	3,500		20	175	175	438	6
7	PAINTING OFF ALL RES	2000	13,000		20	650	650	1,625	7
8	ELEVATOR REPAR $2610	2000	1,305		20	65	65	157	8
9	PAINT	2000	677		20	34	34	82	9
10	PAINT	2000	683		20	34	34	82	10
11	NURSE CALL STATION	2000	807		20	40	40	97	11
12	TILES	2000	598		20	30	30	73	12
13	AC REPAIR	2000	652		20	33	33	80	13
14	AC REPAIR	2000	1,729		20	86	86	208	14
15	ELECTRIC WIRING	2000	1,500		20	75	75	181	15
16	HOPKINS ELEVATOR	2000	1,301		20	65	65	152	16
17	HI-GRADE	2000	519		20	26	26	61	17
18	SEWER REPAIR	2000	760		20	38	38	89	18
19	DRYWALL	2000	1,483		20	74	74	173	19
20	ELECTRICAL WIRING	2000	900		20	45	45	105	20
21	FIRE ALARM PANEL REP	2000	595		20	30	30	70	21
22	FIRE ALARM PANEL REP	2000	505		20	25	25	58	22
23	STOVE REPAIR	2000	2,899		20	145	145	326	23
24	PAINTING	2000	19,800		20	990	990	2,228	24
25	BOILER REPAIR	2000	1,250		20	63	63	137	25
26	LIGHT FIXTURES,LAMPS	2000	41,012		20	2,051	2,051	4,444	26
27	UPGRADE FROM LIGHTIN	2000	2,375		20	119	119	258	27
28	REPLACE PUMP IN HOT	2000	2,117		20	106	106	230	28
29	GLASS BLOCKS	2000	500		20	25	25	52	29
30	BOILER TREATMENT	2000	997		20	50	50	104	30
31	LOCKER ROOM AIR HAND	2000	606		20	30	30	63	31
32	WATER PUMP	2000	539		20	27	27	56	32
33	SEWER LINES CLEANING	2000	1,861		20	93	93	194	33
34	TOTAL (lines 1 thru 33)		$ 11,194,501	$ 363,144		$ 346,845	$ (16,299)	$ 1,116,028	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 11,194,501	$ 363,144		$ 346,845	$ (16,299)	$ 1,116,028	1
2	REPLACING DRAINS I	2000	475		20	24	24	50	2
3	GAS PIPING INSTALLAT	2000	2,655		20	133	133	277	3
4	TILING	2000	10,029		20	501	501	1,044	4
5	SHELVES	2001	990		20	50	50	100	5
6	BATHROOM RENOVATION	2001	819		20	41	41	82	6
7	ELECTRICAL REPAIRS	2001	5,401		20	270	270	540	7
8	BLINDS	2001	1,550		20	78	78	156	8
9	ALCO SALES & SERVICE	2001	741		20	37	37	71	9
10	PAINT	2001	1,113		20	56	56	107	10
11	AC REPAIR	2001	1,357		20	68	68	130	11
12	BATHROOMS RENOVATION	2001	1,067		20	53	53	102	12
13	TILING	2001	783		20	39	39	75	13
14	TILING	2001	559		20	28	28	54	14
15	NURSE CALL STATION	2001	700		20	35	35	67	15
16	KING OF TILE, INC.	2001	942		20	47	47	86	16
17	DURALINE OVERHEAD	2001	3,028		20	151	151	277	17
18	TILES	2001	3,838		20	192	192	352	18
19	TILES	2001	500		20	25	25	46	19
20	TRANSFORMER FOR HEAT	2001	445		20	22	22	40	20
21	WINDOW INSTALLATION	2001	15,000		20	750	750	1,313	21
22	COOLER REPAIR	2001	751		20	38	38	67	22
23	OUTSIDE LIGHTING	2001	6,003		20	300	300	525	23
24	LANDSCAPING	2001	590		20	30	30	53	24
25	CLEAN UP SEWER LINES	2001	2,539		20	127	127	212	25
26	DOORS	2001	2,610		20	131	131	218	26
27	FAN REPAIR	2001	561		20	28	28	44	27
28	BOILER REPAIR	2001	3,247		20	162	162	257	28
29	LANDSCAPING	2001	1,153		20	58	58	92	29
30	INSTALL EMERGENCY	2001	1,113		20	56	56	89	30
31	SEWER PUMP	2001	879		20	44	44	70	31
32	REPAIR GROUND PUMP	2001	2,963		20	148	148	222	32
33	INSTALL EMERGENCY LI	2001	4,295		20	215	215	323	33
34	TOTAL (lines 1 thru 33)		$ 11,273,197	$ 363,144		$ 350,782	$ (12,362)	$ 1,123,169	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 11,273,197	$ 363,144		$ 350,782	$ (12,362)	$ 1,123,169	1
2	SHOWERS RENOVATION	2001	758		20	38	38	57	2
3	PAINT	2001	792		20	40	40	57	3
4	PAINT	2001	1,749		20	87	87	123	4
5	COOLER REPAIR	2001	1,221		20	61	61	86	5
6	HEATING AND AC	2001	54,659		20	2,733	2,733	3,872	6
7	SELF-CLOSING DOOR	2001	4,900		20	245	245	347	7
8	DOORS	2001	800		20	40	40	53	8
9	HAND RAILS	2001	2,500		20	125	125	167	9
10	ROOF REPAIR	2001	2,150		20	108	108	144	10
11	BOILER TREATMENT	2001	997		20	50	50	63	11
12	REPAIR MOTOR PUMP	2001	2,819		20	141	141	176	12
13	EXHAUST FAN	2001	1,446		20	72	72	90	13
14	PIPE SYSTEM UPGRADE	2001	7,289		20	364	364	455	14
15	SEWER LINE REPAIR	2001	2,563		20	128	128	160	15
16	SEWER LINE REPAIR	2001	3,200		20	160	160	200	16
17	WINDOW SHADES	2001	1,072		20	54	54	63	17
18	LANDSCAPING	2001	53,671		20	2,684	2,684	3,131	18
19	HVAC REPLACEMENT	2001	3,116		20	156	156	195	19
20	PAINT	2001	890		20	45	45	60	20
21	PAINT	2001	1,246		20	62	62	78	21
22	GLASS FOR METAL FRAM	2001	1,785		20	89	89	163	22
23	GLASS FOR WINDOWS	2001	935		20	47	47	71	23
24	REPLACE MOTOR UPGRAD	2001	970		20	49	49	61	24
25	NURSE CALL SYSTEM	2002	17,000		20	1,700	1,700	1,700	25
26	KNOB LOCK	2002	840		20	84	84	84	26
27	PLUMBING SUPPLIES	2002	610		20	56	56	56	27
28	DOOR CURTAINS	2002	1,068		20	98	98	98	28
29	SEWER LINES	2002	5,237		20	480	480	480	29
30	TUCKPOINTING	2002	1,000		20	92	92	92	30
31	PLASTER CAULKING, TUCKPOINTING	2002	8,000		20	667	667	667	31
32	CANOPY	2002	3,494		20	291	291	291	32
33	WINDOW SHADES	2002	723		20	60	60	60	33
34	TOTAL (lines 1 thru 33)		$ 11,462,697	$ 363,144		$ 361,888	$ (1,256)	$ 1,136,569	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 11,462,697	$ 363,144		$ 361,888	$ (1,256)	$ 1,136,569	1
2	MAGNETIC DOOR REPAIR	2002	680		20	57	57	57	2
3	METAL DOOR INSTALLATION	2002	670		20	56	56	56	3
4	FIRE ALARM REPAIR	2002	1,530		20	128	128	128	4
5	PAINT	2002	1,032		20	77	77	77	5
6	SHOWER FAUCET	2002	596		20	45	45	45	6
7	BOILER REPAIR	2002	1,535		20	115	115	115	7
8	EXHAUST MOTOR REPLACEMENT	2002	2,950		20	197	197	197	8
9	TAMPER VALVE REPLACEMENT	2002	950		20	63	63	63	9
10	ADT UNIMODE FIRE ALARM	2002	20,693		20	1,380	1,380	1,380	10
11	CANOPY RENTAL	2002	1,648		20	110	110	110	11
12	DOOR	2002	1,775		20	118	118	118	12
13	LANDSCAPING	2002	1,317		20	77	77	77	13
14	AC REPAIR	2002	1,556		20	78	78	78	14
15	ELECTRIC WIRING	2002	1,750		20	88	88	88	15
16	TIMECLOCKS INSTALLATION	2002	506		20	21	21	21	16
17	FIRE SYSTEM REPAIR	2002	1,352		20	56	56	56	17
18	NURSE CALL SYSTEM	2002	552		20	23	23	23	18
19	NURSE CALL SYSTEM	2002	586		20	24	24	24	19
20	NURSE CALL SYSTEM	2002	1,554		20	65	65	65	20
21	BOILER REPAIR	2002	15,665		20	522	522	522	21
22	PAINT	2002	589		20	20	20	20	22
23	TILES	2002	708		20	24	24	24	23
24	FIRE ALARM REPAIR	2002	646		20	22	22	22	24
25	ROOF CEMENT	2002	523		20	13	13	13	25
26	BOILER REPAIR	2002	2,849		20	71	71	71	26
27	BOILER REPAIR	2002	2,000		20	50	50	50	27
28	REROOFING	2002	3,500		20	88	88	88	28
29	NEW FRONT DOOR	2002	800		20	20	20	20	29
30	STRUCTURAL ENGINEER SERVICE	2002	750		20	19	19	19	30
31	SEWER STUDY	2002	600		20	15	15	15	31
32	CAST IRON PIPING REPAIR	2002	6,110		20	102	102	102	32
33	CAST IRON PIPING REPAIR	2002	560		20	9	9	9	33
34	TOTAL (lines 1 thru 33)		$ 11,541,229	$ 363,144		$ 365,641	$ 2,497	$ 1,140,322	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 11,541,229	$ 363,144		$ 365,641	$ 2,497	$ 1,140,322	1
2	NEW FRONT DOOR	2002	800		20	13	13	13	2
3	NURSE CALL SYSTEM	2002	2,392		20	40	40	40	3
4	PAINT & TILE	2002	2,671		20	223	223	223	4
5									5
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	1
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28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	1
2									2
3									3
4									4
5									5
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30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,547,092	$ 363,144		$ 365,917	$ 2,773	$ 1,140,598	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1999	$ 9,900,000	$ 296,314	35	$ 282,857	$ (13,457)	$ 983,653	4
5	CCI Alloc		2002	2002	53,460	100	35	149	49	149	5
6	CCI Alloc		1996	1996		2,455	35	2,736	281		6
7											7
8											8
	Improvement Type**										
9											9
10	Allocation from Care Centers, Inc			2002		911	20	62	(849)		10
11	Allocation from Care Centers, Inc			2001		3	20	14	11		11
12	Allocation from Care Centers, Inc			2000		3	20	6	(3)		12
13	Allocation from Care Centers, Inc			1999		44	20	86	42		13
14	Allocation from Care Centers, Inc			1998		18	20	35	17		14
15	Allocation from Care Centers, Inc			1997		176	20	354	178		15
16	Allocation from Care Centers, Inc			1996		459	20	700	241		16
17	Allocation from Care Centers, Inc-Indiana			1997		2	20	58	56		17
18	Allocation from Care Centers, Inc			1994		22	20		(22)		18
19	Allocation from Care Centers, Inc.			1993		10	20		(10)		19
20	Allocation from Care Centers, Inc			2002	49,499	92	20	206	114	110	20
21											21
22											22
23	Somerset Real Estate, LLC			1999	165,717	4,249	20	8,286	4,037	16,642	23
24	Somerset Real Estate, LLC			1999	100,018	2,565	20	5,001	2,436	8,978	24
25	Somerset Real Estate, LLC			1999	70,455	1,807	20	3,523	1,716	6,174	25
26	Somerset Real Estate, LLC			1999	76,104	1,951	20	3,805	1,854	6,503	26
27	Somerset Real Estate, LLC			1999	65,049	1,668	20	3,252	1,584	5,421	27
28	Somerset Real Estate, LLC			1999	109,573	2,809	20	5,479	2,670	3,502	28
29	Somerset Real Estate, LLC			2000	6,139	157	20	307	150	399	29
30	Somerset Real Estate, LLC			2000	7,650	196	20	383	187	5,393	30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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50									50
51									51
52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,603,664	$ 316,011		$ 317,299	$ 1,282	$ 1,036,924	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,512,410	$ 334,525	$ 250,995	$ (83,530)	10	$ 989,503	71
72	Current Year Purchases	44,747	3,429	11,892	8,463	10	11,892	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,557,157	$ 337,954	$ 262,887	$ (75,067)		$ 1,001,395	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	VAN	1999	$ 5,000	$ 588	$ 1,000	$ 412	5	$ 3,417	76
77	FACILITY	INSTALL SEATBELTS	2000	780	150	78	(72)	5	202	77
78	CARE CENTER ALLOC.			62,134	10,453	9,055	(1,398)	5	33,979	78
79										79
80	TOTALS			$ 67,914	$ 11,191	$ 10,133	$ (1,058)		$ 37,598	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,310,957	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 712,289	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 638,937	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (73,352)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,179,591	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

SEE ACCOUNTANTS' COMPILATION REPORT

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Centers, Inc.				10,502			5
6								6
7	TOTAL				$ 10,502 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 19,779 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE | STATE OF ILLINOIS # 0044289 | Report Period Beginning: 01/01/02 Ending: 12/31/02

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			203			203	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						1,732		1,732	13
14	TOTAL			$		$ 203	$ 1,732		$ 1,935	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 92,135	$ 92,784	1
2	Cash-Patient Deposits	100,896	100,896	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,324,698	2,324,698	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	258,005	411,284	6
7	Other Prepaid Expenses	83,838	83,838	7
8	Accounts Receivable (owners or related parties)	53,467	623,467	8
9	Other(specify): See Supplemental Schedule	3,469,494	4,378,378	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 6,382,533	$ 8,015,345	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,100,000	13
14	Buildings, at Historical Cost		9,900,000	14
15	Leasehold Improvements, at Historical Cost	931,943	1,532,648	15
16	Equipment, at Historical Cost	199,761	2,449,761	16
17	Accumulated Depreciation (book methods)	(203,144)	(2,820,181)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		279,777	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(41,967)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule	174,416	10,265,880	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,102,976	$ 22,665,918	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 7,485,509	$ 30,681,263	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 720,428	$ 720,427	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	92,815	92,815	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	360,120	360,120	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,490	20,490	31
32	Accrued Real Estate Taxes(Sch.IX-B)	587,799	587,799	32
33	Accrued Interest Payable		202,712	33
34	Deferred Compensation	5,808	5,808	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	(7,883)	(7,883)	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,779,577	$ 1,982,288	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		28,450,741	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 28,450,741	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,779,577	$ 30,433,029	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,705,932	$ 248,234	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 7,485,509	$ 30,681,263	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,164,441	1	
2	Restatements (describe):		2	
3	**Prior Year Journal Entries for Rent & Depreciation**	35,533	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,199,974	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,930,958	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(1,425,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 505,958	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,705,932	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,206,122	1
2	Discounts and Allowances for all Levels	(1,019)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 14,205,103	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,019	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,019	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	209,743	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 209,743	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	332	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 332	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,416,197	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,137,247	31
32	Health Care	3,674,050	32
33	General Administration	3,001,018	33
	B. Capital Expense		
34	Ownership	3,424,614	34
	C. Ancillary Expense		
35	Special Cost Centers	1,935	35
36	Provider Participation Fee	246,375	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,485,239	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,930,958	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,930,958	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,005	2,181	$ 69,125	$ 31.70	1
2	Assistant Director of Nursing	5,455	6,154	145,978	23.72	2
3	Registered Nurses	4,297	4,901	105,534	21.53	3
4	Licensed Practical Nurses	42,016	46,511	885,322	19.03	4
5	Nurse Aides & Orderlies	132,342	145,070	1,283,136	8.84	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,837	2,148	20,429	9.51	8
9	Activity Director	7,769	8,510	118,948	13.98	9
10	Activity Assistants	22,614	24,464	179,001	7.32	10
11	Social Service Workers	43,537	49,156	692,796	14.09	11
12	Dietician	6,989	8,023	100,533	12.53	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	40,299	43,958	308,093	7.01	15
16	Dishwashers					16
17	Maintenance Workers	9,142	10,287	145,864	14.18	17
18	Housekeepers	41,829	45,887	319,534	6.96	18
19	Laundry	1,856	2,051	17,156	8.36	19
20	Administrator	1,766	1,910	77,069	40.35	20
21	Assistant Administrator	2,145	2,417	46,999	19.45	21
22	Other Administrative	2,080	2,080	300,000	144.23	22
23	Office Manager					23
24	Clerical	14,510	16,411	191,077	11.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,074	3,506	40,191	11.46	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	385,560	425,624	$ 5,046,785 *	$ 11.86	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	372	$ 34,278	01-03	35
36	Medical Director	Monthly	12,000	09-03	36
37	Medical Records Consultant	Qtr Fee	1,472	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	3,600	10-03	39
40	Physical Therapy Consultant	$.90 per min.	311	10a-03	40
41	Occupational Therapy Consultant	$.90 per min.	1,953	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	4	192	11-03	44
45	Social Service Consultant	Per Consult	60	12-03	45
46	Other(specify)				46
47					47
48	Care Centers (see attached)		23,818	Various	48
49	TOTAL (lines 35 - 48)	376	$ 77,684		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	32	1,088	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	32	$ 1,088		53

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ERIC ROTHNER	ADMINISTRATION	0	$ 300,000
KAREN JAMES	ADMINISTRATOR	0	77,069
BLAKE WILLEY	ASST ADMINISTRATOR	0	46,999
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 424,068

B. Administrative - Other

Description	Amount
Eric Rothner-Management Fee	$ 300,000
Nathan Langner-Management Fee	12,000
Administrative Payroll (See Page 6B)	31,090
TOTAL (agree to Schedule V, line 17, col. 3)	$ 343,090
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
FR&R	Accounting	$ 13,755
PAYCOR	Data Processing	13,915
PERSONNEL PLANNERS	Unemployment Consulting	4,354
LEGAT ARCHITECTS	Architect Fees	3,990
CARE CENTERS, INC	Various (see attached)	596,063
MICHAEL BEST	Legal	3,328
NEAL GERBER	Legal	121
DAIWA	Audit Fees	1,497
TEG	Utility Management Services	225
C. ZOLA	IOC Consultant	33
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 637,280

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 84,591
Unemployment Compensation Insurance	47,756
FICA Taxes	357,233
Employee Health Insurance	272,239
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	10,266
PENSION	60,575
MISC EMP WELL	11,064
EMPLOYEE PHYSICALS	3,854
TOTAL (agree to Schedule V, line 22, col.8)	$ 847,578

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	9,391
Health Care Worker Background Check	
(Indicate # of checks performed 275)	2,996
YELLOW PAGE ADVERTISING	90
ADVERTISING	48,981
DUES & SUBSCRIPTIONS	15,453
LICENSES & FEES	8,514
CARE CENTER ALLOACATION	3,031
Less: Public Relations Expense	(48,981)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,675

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,585
CARE CENTER ALLOCATION	2,255
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,840

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number SOMERSET PLACE # 0044289 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE-$21,546.00**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,444** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **246,375**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **YES** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%IN14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees